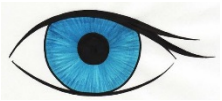

GLENS FALLS EYE ASSOCIATES, PC.
535 BAY ROAD
QUEENSBURY, NY 12804
(518) 793-0331

REGISTRATION FORM

TODAY'S DATE_____

PATIENT INFORMATION_____

Last Name_____ First_____ Middle_____
SSN#_____ Date of Birth_____ Sex: M_____ F_____
Street Address_____ PO Box_____ City_____
State_____ Zip Code _____ Email _____
Home Phone_____ Cell Phone_____ Work Phone _____
Employer_____ Address _____
Emergency Contact _____ Phone Number _____ Relation _____
Referring Physician _____ Primary Care Physician _____

INSURANCE INFORMATION

Name of Insurance Company _____ Address _____
ID Number _____ Phone Number _____
Guarantor's Name _____ Address _____
Guarantor's Best Phone Number to be Reached _____
Employer _____ Address _____ Phone Number _____

Secondary Plan

Name of Insurance Company _____ Address _____
ID Number _____ Phone Number _____
Guarantor's Name _____ Address _____

The Above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize GLENS FALLS EYE ASSOCIATES, PC., 535 BAY ROAD, QUEENSBURY, NY 12804 (518) 793-0331 registration form or insurance company to release any information required to process my claim.

_____ _____

Patient/Guardian Signature *Date*